LETTER TO TREATING PHYSICIAN - SAFETY CRITICAL POSITIONS

Dear Treating Physician,

Canadian Pacific Railway (CP) has a Return to Work Program to assist injured or ill workers back to pre-injury/illness duties as soon as they are medically able. This program includes modified or alternate duties for employees with work limitations and/or restrictions.

The objectives of CP's RTW program are to:

1) Provide the support and accommodations necessary for an employee's early, safe and sustained return to their pre-injury or illness duties;
2) Assist employees in their recovery process;
3) Help employees avoid financial and personal difficulties often caused by being off work; and,
4) Minimize WCB claim costs.

At CP, we believe in a safe and timely return to work for our employees. Therefore, we make every effort to **accommodate any restriction/limitations an employee may have**. The tasks can range from sedentary to moderately heavy. Accommodations are customized to the individual based on his or her restrictions and/or limitations.

Included in this package is a CP Functional Abilities Form (FAF). In order for us to provide this employee with appropriate job duties within their medical restrictions, please complete Parts 4 and 5 of the FAF.

Safety Critical Positions are mandated by the Railway Safety Act and have a direct role in safe railway operations where impaired performance due to a medical condition could result in a significant incident affecting the health and safety of employees, the public, property or the environment. e.g. Locomotive Engineers, Conductors and Rail Traffic Controllers. The attached Job Demands Analysis will assist you in understanding the job requirements.

You are responsible under the Railway Safety Act to notify the Railway Company Chief Medical Officer if an employee has a medical condition that could be a threat to safe railway operations. These conditions are listed in Part 5 of the attached Functional Abilities Form (FAF) and, if your patient is currently presenting with these condition(s), you are required to report them in Part 5 of the form.

IMPORTANT – If you are reporting that the employee is totally unfit for any work at any level, including tasks that only require sitting at a desk, please complete Part 5 of the FAF and provide objective medical information why he or she cannot perform non-safety sensitive sedentary duties.

Please fax the completed form and invoice directly to CP's Occupational Health Services at 1 403 319 6803.

If you have any questions regarding our RTW Program or have issues or concerns with completing these forms, please contact us at 1-866-876-0879.

Thank you for your cooperation and assistance with your patient's return to work.

Lisa Trueman
Director, Health Services
Canadian Pacific Railway

References:

- Canadian Railway Medical Rules for Positions Critical to Safe Railway Operations (http://www.railcan.ca/publications/rule_handbook)
- CMA Driver's Guide – Determining Medical Fitness to Operate Motor Vehicles 8th Edition. (http://www.cma.ca/driversguide)

CANADIAN PACIFIC

FUNCTIONAL ABILITIES FORM
SAFETY CRITICAL POSITIONS

PART 1 – INFORMATION FOR THE TREATING PHYSICIAN **TO BE READ BY TREATING PHYSICIAN**

Your patient occupies a Safety Critical Position and **operates or controls the movement of trains.** Impaired performance due to a medical condition could result in a significant incident affecting the health and safety of employees, the public, property or the environment. **As a physician assessing persons occupying these positions you are responsible under the Railway Safety Act to notify the Railway Company's Chief Medical Officer if an employee has a medical condition that could be a threat to safe railway operations.**

Canadian Pacific Railway (CP) appreciates your time in completing this form and will pay you on receipt of the attached invoice. Capabilities that must be reviewed when assessing medical fitness for railway employees in Safety Critical Positions are provided with this form.

PLEASE FOLLOW THESE STEPS:

1. **Complete Part 4** (Functional Abilities) **and Part 5** (Medical Report).
2. **Complete Part 6** (Invoice)
3. **Fax the completed form to CP's Occupational Health Services (OHS) at (403)319-6803.**

PART 2 – EMPLOYEE INFORMATION **TO BE COMPLETED BY THE SUPERVISOR**

NAME OF EMPLOYEE: EMPLOYEE NUMBER:

POSITION/JOB NAME: TELEPHONE #: ( )

THIS INJURY/ILLNESS IS COVERED UNDER: ☐ WCB/WSIB/CSST ☐ WIB ☐ STD ☐ LTD

DATE OF INJURY/ILLNESS: MARVIN INCIDENT #:

NAME OF SUPERVISOR:

PHONE # OF SUPERVISOR: ( ) **FAX # : (403) 319 – 6803**

PART 3 – EMPLOYEE CONSENT **TO BE COMPLETED BY THE EMPLOYEE**

I authorize the healthcare professional who has signed this form to release to CP, i.e. my supervisor, Return To Work Specialist, Occupational Health Services and, where applicable, the WCB Specialist, any functional limitations and/or restrictions information that is relevant to my return to work. I also authorize my healthcare professional to release to and discuss information concerning my present medical condition, solely, with the office of CP's Chief Medical Officer in OHS. Furthermore, I authorize CP to release Parts 1 through 4 of this form to the appropriate union representative for the purposes of return to work planning. I also authorize OHS, CP, to release all or a portion of the medical information that is relevant to the adjudication of any benefit claim related to my present medical condition to CP's WCB Specialist and the applicable Workers' Compensation Board (WCB) and/or Benefit Carrier. I further authorize OHS to release relevant medical information to CP's Supervisors where necessary to manage the employment relationship including investigating misconduct or performance issues, to assess the duty to accommodate and compliance with last chance/reinstatement/employment agreements, or to Industrial/Labour Relations and my Union Representative for the purposes of responding to grievance/arbitration or other proceedings when the information is relevant to the proceeding. Any use and disclosure of my medical information will be in accordance with legal requirements and CP Policy 1804, Privacy of Information. I also consent to receiving correspondence from OHS related to my medical condition(s) and assessments by email. This consent is valid for a period of six (6) months from the date signed below. Any medical information received by OHS will be kept in my confidential occupational health file. I understand that a copy of this consent is as valid as the original.

x_____ x_____ _____
Employee Signature Witness Signature Date (dd/mm/yy)

x_____
Employee Email Address

PART 4 – FUNCTIONAL ABILITIES **TO BE COMPLETED BY THE TREATING PHYSICIAN**
(Please ensure NO confidential medical information is included in this part of the form)

Patient Name: _____

Date of exam on which this report is based: _____ (dd/mm/yy)

☐ **FIT for the USUAL DUTIES** of this position (as described on Job Demands Analysis)
☐ Immediately ☐ As of:_____ (dd/mm/yy)

☐ **FIT for MODIFIED / ALTERNATE DUTIES:**
☐ Immediately ☐ As of:_____ (dd/mm/yy) Duration of modified/alternate duties: _____ (week(s)/day(s))

PLEASE COMPLETE EACH SET OF CHOICES BELOW:

WALKING (select all that apply)
☐ No limitations
☐ Limited uneven ground (loose rock, steep slopes, heavy/deep snow)
☐ No prolonged periods > 30 minutes
☐ Not more than 100 meters
☐ Unable to walk without assistance (cane, crutches)

CLIMBING AND BALANCE (select all that apply)
☐ No limitations
☐ Stairs only, no vertical ladders
☐ No working at heights (over 6 feet)

STRENGTH (lifting, carrying, pushing, pulling)
☐ No limitations
☐ Heavy Over 50 lbs occasionally
☐ Medium Up to 20 lbs regularly – 50 lbs occasionally
☐ Light Up to 10 lbs regularly – 20 lbs occasionally
☐ Sedentary Up to 10 lbs occasionally.

POSTURES (select all that apply)
☐ No limitations
☐ Must be able to change from sitting to standing at own discretion
☐ No sitting duration > 30 minutes
☐ No standing duration > 30 minutes

UPPER LIMB (select all that apply)
☐ No limitations
☐ No above shoulder reaching: ☐ Left ☐ Right
☐ No firm gripping or twisting: ☐ Left ☐ Right
☐ No writing or keyboard use: ☐ Left ☐ Right

OPERATING MOVING EQUIPMENT (select one)
☐ Can operate moving equipment
☐ Should NOT operate moving equipment

DRIVING COMPANY VEHICLES (select all that apply)
☐ Can drive Company vehicles (as per license) and is meeting fitness to drive requirements for:
  ☐ private driving ☐ commercial driving
☐ No driving of Company vehicles, and if so:
  ☐ Patient is unfit to drive (private)
  ☐ Patient is unfit to drive (commercial)
  ☐ Recommendation made to Prov. Licensing Authority
  ☐ License suspended by Prov. Licensing authority

SAFETY CONCERNS/COGNITIVE FUNCTION (select one)
☐ Normal cognitive function for alertness, concentration, attention, judgment, and memory. **(Employee may be placed in safety sensitive or critical position)**
☐ Some cognitive function impairment present. **(Employee must be placed in a Non-Safety Sensitive Position)**

WORK DAY DURATION (select one)
☐ Able to work full shift
☐ Graduated Work Schedule: ___hrs/day for___week(s)

PROGNOSIS:
Complete Recovery expected: ☐ YES ☐ NO Estimated duration of restrictions:_____week(s) ☐ Over 3 mths
Date of next appointment/reassessment:_____(dd/mm/yy)

☐ ****Totally UNFIT for any work.** Date of reassessment: _____ (dd/mm/yy) Date of expected RTW:_____ (dd/mm/yy)

If you are indicating that your patient is "Totally UNFIT for <u>any</u> work" **(including non-safety sensitive, sedentary office-type duties)**, you MUST also complete the Part 5 – Medical Report and <u>provide objective medical evidence</u> that supports Temporary Total Disability. **In the absence of this information CP may offer temporary accommodation in non safety sensitive sedentary office type duties.**

TREATING PHYSICIAN (please print)

Name (Print):_____ ☐ Family Physician ☐ Specialist (Specify):_____

Signature:_____ Date: _____(dd/mm/yy)

PART 5 – MEDICAL REPORT **TO BE COMPLETED BY TREATING PHYSICIAN**

MUST COMPLETE IF YOUR PATIENT IS PRESENTING AS BEING OFF WORK DUE TO ANY OF THE FOLLOWING MEDICAL CONDITION(S):

- Significant Hearing or Vision Deficits
- Mental Disorder
- Substance Use Disorder (abuse or dependence)
- Severe Sleep Apnea
- Epileptic Seizure
- Cardiovascular Disorder
- Diabetes
- Opioid Pain Medication Use

- OR, Any other medical condition which may pose a threat to safe railway operations.
- OR, You indicate that your patient is totally unfit for any work including non-safety sensitive, sedentary, office-type duties.

Patient Name: _____ DOB (dd/mm/yy):_____

DIAGNOSIS (please be specific):

A)_____ B) _____

C) _____ D) _____

TREATMENT – Completed and Current: (indicate dates)

Surgery _____ Date (dd/mm/yy)_____
Hospitalization _____ Date(dd/mm/yy)_____
Rehabilitation Program_____ Date(dd/mm/yy)_____
Referrals _____ Date(dd/mm/yy)_____
Investigations_____ Date(dd/mm/yy)_____
Other _____ Date (dd/mm/yy)_____

CURRENT MEDICATIONS: (name, dosage, and expected duration of use)

Name :_____ Dosage:_____ Duration:_____
Name :_____ Dosage:_____ Duration:_____
Name :_____ Dosage:_____ Duration:_____
Other(s):_____

EFFECTS ON COGNITION: please provide your opinion on any adverse affects due to medication(s) AND/OR medical condition(s) as related to:

	NO	YES		NO	YES
Alertness	☐	☐	Memory	☐	☐
Attention	☐	☐	Mood	☐	☐
Orientation	☐	☐	Psychomotor functions	☐	☐
Judgment	☐	☐			

In your opinion, does your patient suffer from any medical condition that can result in sudden impairment?

☐ NO ☐ YES, please explain:_____

In your opinion, is your patient capable of performing the duties of a Safety Critical Position?

☐ YES ☐ NO, please explain:_____

Do you wish to discuss your patient's condition with the Company's Occupational Health Nurse?

☐ NO ☐ YES, please specify the issue: _____

Please append copies of relevant reports from specialists, laboratory, physiotherapy, x-rays, etc.

Treating Physician Name (please print)

Name (Print):_____ ☐ Family Physician ☐ Specialist (Specify):_____

Signature_____ Date: _____
(dd/mm/yy)

PART 6 – INVOICE (SCP FAF)

On receipt of the completed report, Canadian Pacific Railway agrees to pay to the treating physician a fee of $100 for completion of Part 4 and Part 5. This fee is used as a guide. It is appreciated that in some circumstances a greater fee may be appropriate commensurate with the physician's time and the detail of the information provided. In such circumstances, a fee in accordance with the current provincial guidelines for uninsured services would be appropriate. No additional invoice is necessary. Please provide in the space below the person to whom the cheque should be made payable, and the address.

PLEASE WRITE LEGIBLY TO ASSIST US IN PROCESSING YOUR PAYMENT

TO BE COMPLETED FOR PAYMENT:

Name of Patient:_____

Date form completed:_____ (dd/mm/yy)

Payment made payable to:_____

TREATING PHYSICIAN NAME (**PRINT)**:_____

TREATING PHYSICIAN ADDRESS:_____
_____
_____
_____
_____
_____

TELEPHONE: ( ) _____ FAX: ( ) _____

FOR CANADIAN PACIFIC RAILWAY USE ONLY

AMOUNT: ☐ $100 CANADIAN ACCOUNT:65802 INVOICE #:_____

COCODE: 1000 ORDER # 7005727 ORDER: YES

I HAVE READ AND APPROVE ACCORDING TO POLICY 6137

SIGNATURE:_____ EMPLOYEE # 964936

Fax the completed form to CP Occupational Health Services (OHS) at (403) 319-6803

FUNCTIONAL ABILITIES FORM
SAFETY CRITICAL POSITIONS

PART 1 – INFORMATION FOR THE TREATING PHYSICIAN **TO BE READ BY TREATING PHYSICIAN**

Your patient occupies a Safety Critical Position and **operates or controls the movement of trains.** Impaired performance due to a medical condition could result in a significant incident affecting the health and safety of employees, the public, property or the environment. **As a physician assessing persons occupying these positions you are responsible under the Railway Safety Act to notify the Railway Company's Chief Medical Officer if an employee has a medical condition that could be a threat to safe railway operations.**

Canadian Pacific Railway (CP) appreciates your time in completing this form and will pay you on receipt of the attached invoice. Capabilities that must be reviewed when assessing medical fitness for railway employees in Safety Critical Positions are provided with this form.

PLEASE FOLLOW THESE STEPS:

4. **Complete Part 4** (Functional Abilities) **and Part 5** (Medical Report).
5. **Complete Part 6** (Invoice)
6. **Fax the completed form to CP's Occupational Health Services (OHS) at (403)319-6803.**

PART 2 – EMPLOYEE INFORMATION **TO BE COMPLETED BY THE SUPERVISOR**

NAME OF EMPLOYEE: EMPLOYEE NUMBER:

POSITION/JOB NAME: TELEPHONE #: ( )

THIS INJURY/ILLNESS IS COVERED UNDER: ☐ WCB/WSIB/CSST ☐ WIB ☐ STD ☐ LTD

DATE OF INJURY/ILLNESS: MARVIN INCIDENT #:

NAME OF SUPERVISOR:

PHONE # OF SUPERVISOR: ( ) **FAX # : (403) 319 – 6803**

PART 3 – EMPLOYEE CONSENT **TO BE COMPLETED BY THE EMPLOYEE**

I authorize the healthcare professional who has signed this form to release to CP, i.e. my supervisor, Return To Work Specialist, Occupational Health Services and, where applicable, the WCB Specialist, any functional limitations and/or restrictions information that is relevant to my return to work. I also authorize my healthcare professional to release to and discuss information concerning my present medical condition, solely, with the office of CP's Chief Medical Officer in OHS. Furthermore, I authorize CP to release Parts 1 through 4 of this form to the appropriate union representative for the purposes of return to work planning. I also authorize OHS, CP, to release all or a portion of the medical information that is relevant to the adjudication of any benefit claim related to my present medical condition to CP's WCB Specialist and the applicable Workers' Compensation Board (WCB) and/or Benefit Carrier. I further authorize OHS to release relevant medical information to CP's Supervisors where necessary to manage the employment relationship including investigating misconduct or performance issues, to assess the duty to accommodate and compliance with last chance/reinstatement/employment agreements, or to Industrial/Labour Relations and my Union Representative for the purposes of responding to grievance/arbitration or other proceedings when the information is relevant to the proceeding. Any use and disclosure of my medical information will be in accordance with legal requirements and CP Policy 1804, Privacy of Information. I also consent to receiving correspondence from OHS related to my medical condition(s) and assessments by email. This consent is valid for a period of six (6) months from the date signed below. Any medical information received by OHS will be kept in my confidential occupational health file. I understand that a copy of this consent is as valid as the original.

x_____ x_____ _____
Employee Signature Witness Signature Date (dd/mm/yy)

x_____
Employee Email Address

PART 4 – FUNCTIONAL ABILITIES **TO BE COMPLETED BY THE TREATING PHYSICIAN**
(Please ensure NO confidential medical information is included in this part of the form)

Patient Name: _____

Date of exam on which this report is based: _____ (dd/mm/yy)

☐ **FIT for the USUAL DUTIES** of this position (as described on FTW Considerations for Safety Critical Positions)
☐ Immediately ☐ As of:_____ (dd/mm/yy)

☐ **FIT for MODIFIED / ALTERNATE DUTIES:**
☐ Immediately ☐ As of:_____ (dd/mm/yy) Duration of modified/alternate duties: _____ (week(s)/day(s))

PLEASE COMPLETE EACH SET OF CHOICES BELOW:

WALKING (select all that apply)
☐ No limitations
☐ Limited uneven ground (loose rock, steep slopes, heavy/deep snow)
☐ No prolonged periods > 30 minutes
☐ Not more than 100 meters
☐ Unable to walk without assistance (cane, crutches)

CLIMBING AND BALANCE (select all that apply)
☐ No limitations
☐ Stairs only, no vertical ladders
☐ No working at heights (over 6 feet)

STRENGTH (lifting, carrying, pushing, pulling)
☐ No limitations
☐ Heavy Over 50 lbs occasionally
☐ Medium Up to 20 lbs regularly – 50 lbs occasionally
☐ Light Up to 10 lbs regularly – 20 lbs occasionally
☐ Sedentary Up to 10 lbs occasionally.

POSTURES (select all that apply)
☐ No limitations
☐ Must be able to change from sitting to standing at own discretion
☐ No sitting duration > 30 minutes
☐ No standing duration > 30 minutes

UPPER LIMB (select all that apply)
☐ No limitations
☐ No above shoulder reaching: ☐ Left ☐ Right
☐ No firm gripping or twisting: ☐ Left ☐ Right
☐ No writing or keyboard use: ☐ Left ☐ Right

OPERATING MOVING EQUIPMENT (select one)
☐ Can operate moving equipment
☐ Should NOT operate moving equipment

DRIVING COMPANY VEHICLES (select all that apply)
☐ Can drive Company vehicles (as per license) and is meeting fitness to drive requirements for:
  ☐ private driving ☐ commercial driving
☐ No driving of Company vehicles, and if so:
  ☐ Patient is unfit to drive (private)
  ☐ Patient is unfit to drive (commercial)
  ☐ Recommendation made to Prov. Licensing Authority
  ☐ License suspended by Prov. Licensing authority

SAFETY CONCERNS/COGNITIVE FUNCTION (select one)
☐ Normal cognitive function for alertness, concentration, attention, judgment, and memory. **(Employee may be placed in safety sensitive or critical position)**
☐ Some cognitive function impairment present. **(Employee must be placed in a Non-Safety Sensitive Position)**

WORK DAY DURATION (select one)
☐ Able to work full shift
☐ Graduated Work Schedule: ___hrs/day for___week(s)

PROGNOSIS:
Complete Recovery expected: ☐ YES ☐ NO Estimated duration of restrictions:_____week(s) ☐ Over 3 mths
Date of next appointment/reassessment:_____(dd/mm/yy)

☐ ****Totally UNFIT for any work.** Date of reassessment: _____ (dd/mm/yy) Date of expected RTW:_____ (dd/mm/yy)

If you are indicating that your patient is "Totally UNFIT for <u>any</u> work" **(including non-safety sensitive, sedentary office-type duties)**, you MUST also complete the Part 5 – Medical Report and <u>provide objective medical evidence</u> that supports Temporary Total Disability. **In the absence of this information CP may offer temporary accommodation in non safety sensitive sedentary office type duties.**

TREATING PHYSICIAN (please print)

Name (Print):_____ ☐ Family Physician ☐ Specialist (Specify):_____

Signature:_____ Date: _____(dd/mm/yy)

PART 5 – MEDICAL REPORT **TO BE COMPLETED BY TREATING PHYSICIAN AS REQUIRED**

MUST COMPLETE IF YOUR PATIENT IS PRESENTING AS BEING OFF WORK DUE TO ANY OF THE FOLLOWING MEDICAL CONDITION(S):

- Significant Hearing or Vision Deficits
- Mental Disorder
- Substance Use Disorder (abuse or dependence)
- Severe Sleep Apnea
- Epileptic Seizure
- Cardiovascular Disorder
- Diabetes
- Opioid Pain Medication Use

- OR, Any other medical condition which may pose a threat to safe railway operations.
- OR, You indicate that your patient is totally unfit for any work including non-safety sensitive, sedentary, office-type duties.

Patient Name: _____ DOB (dd/mm/yy):_____

DIAGNOSIS (please be specific):

A)_____ B) _____

C) _____ D) _____

TREATMENT – Completed and Current: (indicate dates)

Surgery _____ Date (dd/mm/yy)_____
Hospitalization _____ Date(dd/mm/yy)_____
Rehabilitation Program_____ Date(dd/mm/yy)_____
Referrals _____ Date(dd/mm/yy)_____
Investigations_____ Date(dd/mm/yy)_____
Other _____ Date (dd/mm/yy)_____

CURRENT MEDICATIONS: (name, dosage, and expected duration of use)

Name :_____ Dosage:_____ Duration:_____
Name :_____ Dosage:_____ Duration:_____
Name :_____ Dosage:_____ Duration:_____
Other(s):_____

EFFECTS ON COGNITION: please provide your opinion on any adverse affects due to medication(s) AND/OR medical condition(s) as related to:

	NO	YES		NO	YES
Alertness	☐	☐	Memory	☐	☐
Attention	☐	☐	Mood	☐	☐
Orientation	☐	☐	Psychomotor functions	☐	☐
Judgment	☐	☐			

In your opinion, does your patient suffer from any medical condition that can result in sudden impairment?

☐ NO ☐ YES, please explain:_____

In your opinion, is your patient capable of performing the duties of a Safety Critical Position?

☐ YES ☐ NO, please explain:_____

Do you wish to discuss your patient's condition with the Company's Occupational Health Nurse?

☐ NO ☐ YES, please specify the issue: _____

Please append copies of relevant reports from specialists, laboratory, physiotherapy, x-rays, etc.

Treating Physician Name (please print)

Name (Print):_____ ☐ Family Physician ☐ Specialist (Specify):_____

Signature_____ Date: _____
(dd/mm/yy)

PART 6 – INVOICE (SCP FAF)

On receipt of the completed report, Canadian Pacific Railway agrees to pay to the treating physician a fee of $100 for completion of Part 4 and Part 5. This fee is used as a guide. It is appreciated that in some circumstances a greater fee may be appropriate commensurate with the physician's time and the detail of the information provided. In such circumstances, a fee in accordance with the current provincial guidelines for uninsured services would be appropriate. No additional invoice is necessary. Please provide in the space below the person to whom the cheque should be made payable, and the address.

PLEASE WRITE LEGIBLY TO ASSIST US IN PROCESSING YOUR PAYMENT

TO BE COMPLETED FOR PAYMENT:

Name of Patient:_____

Date form completed:_____ (dd/mm/yy)

Payment made payable to:_____

TREATING PHYSICIAN NAME (**PRINT)**:_____

TREATING PHYSICIAN ADDRESS:_____
_____
_____
_____
_____
_____

TELEPHONE: ( ) _____ FAX: ( ) _____

FOR CANADIAN PACIFIC RAILWAY USE ONLY

AMOUNT: ☐ $75 CANADIAN ACCOUNT:65802 INVOICE #:_____

☐ $100 CANADIAN

COCODE: 1000 ORDER # 7005727 ORDER: YES

I HAVE READ AND APPROVE ACCORDING TO POLICY 6137

SIGNATURE:_____ EMPLOYEE # 964936

Fax the completed form to CP Occupational Health Services (OHS) at (403) 319-6803

Return to Work (RTW) Program: Employee Responsibilities

If you are injured or become ill, it is your responsibility to:

- **Report all work-related injuries and illnesses immediately** to your Front Line Manager (FLM)/Supervisor in the prescribed manner.
- **Report all absences related to non-occupational injuries or illnesses immediately** to your FLM/Supervisor in the prescribed manner.
- See your Doctor as soon as possible for appropriate assessment, care and treatment, and take a RTW Package with you.
- Advise the Doctor that the Functional Abilities Form should be completed during the office visit so that it may be returned to the workplace by fax or by hand **within seventy- two (72) hours**.
- If the FAF is not completed during the doctor's visit, **you must follow-up with your Doctor** to ensure that the form is faxed to the appropriate recipient in a timely manner.
- Comply with any treatment plans or recommendations of your Doctor or other treatment provider(s).
- Attend all medical or rehabilitation appointments as required.
- Participate fully and to the best of your ability in the RTW Program, RTW planning, and modified duties.
- While participating in the RTW Program, maintain regular contact with your Doctor, treatment providers, and FLM/Supervisor advising of progress or concerns and working together to make adjustments as necessary to ensure every opportunity for your successful return to work.
- If unable to continue with the return to work plan, provide and outline reasons for discontinuing by providing supporting documentation in a timely manner - i.e. updated FAF.
- For injuries or illness that results in lost time, maintain contact by telephone with your FLM/Supervisor at least once per week or as directed by your FLM/Supervisor, to provide updates on your progress and RTW.
- Supply updated medical assessments or reports (Functional Abilities Forms, physician notes, WCB/WSIB physician reporting forms, etc) as requested by your FLM/Supervisor, CP's Occupational Health Nurse, or RTW Specialist.